Intake Form
Veronica J. Ahern, MA, LP

Date ___________________________ DX Code __________________________________

Client Information

Client Name (Print) ____ Date of Birth ____________________________
Last Name First Name Initial
Street Address ____ Home Phone ____________________________

City ____ State _________ ZIP _________________ Work Phone ____________________________

Emergency Contact _________________________________ Contact's Cell Phone _______________________ Client's Cell Phone ________________________

Sex: ____Female ____Male Age__________ Marital Status: ___Single ___Married ___Partnered ___Widowed ___Divorced ___ Separated ____Other

Employer ____ Occupation ____

Referred by ____ May we acknowledge this referral ______________________________

Primary Insurance

Primary Insurance Company ____ Phone { } ______________________________

Ins Claims Address ____ City _____________________________ State _________ Zip __________________

Policy / Member ID ____ Group/Account # ____

Policy Holder Information: (if the client is not the employee/policy holder)

Name ____ Date of Birth _________________________
Last name First Name Initial
Address ____ City __________________________ State _______ Zip _______________ Relationship ____________________

Soc. Sec# ______________________________________ Employer ____

Secondary Insurance

Secondary Insurance Company ____ Phone { } _______________________________

Ins Claims Address ____ City ____________________________ State _________ Zip ____________________

Policy / Member ID ____ Group/Account # ______________________________________

Policy Holder Information: (if the patient is not the employee/policy holder)

Name ____ Date of Birth _____________________________
Last name First Name Initial

Address ____ City ___________________________ State ______ Zip ____________ Relationship __________________

Soc. Sec# _____________________________________ Employer ____

Responsible Party (Where should the patient's portion of the bill be sent, if not to the client?)

Name ____ Relationship _____________________________________

Address ____ Phone { } ____

Assignment and Release

I the undersigned, certify that I (or my dependent) have insurance coverage as noted above and assign directly to the healthcare provider listed at the top of this form all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the healthcare provider to release all information necessary to secure the payment of benefits and to mail patient statements. I authorize the use of this signature on all insurance submissions.

____ ______________________________ ________________________________
Responsible Party Signature Relationship Date